Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE NORTH DALLAS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1380-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
JANUARY 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note this patient WON his CONTESTED CASE HEARING on 5/30/13, and I have attached the results. I have attached all the necessary documentation."

Amount in Dispute: $1,319.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay disputed dates, except codes 99080, 2/27/13, 3/4/13, 3/6/13, 3 /13/13, 5/14/13, 7/1/13, 7/9/13, and 7/18/13. The requestor billed a DWC-73 for date 3/18/13. The -73 for 3/18/13 remains unchanged from that of 3/4/13 with respect to the work status. (Attachment) Rule 129.4(d) states, ' The doctor shall file the Work Status Report: (1) the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee.' Texas Mutual did not request schedule receipt every two weeks of the report. For these reasons Texas Mutual declined to issue payment. The same applies for dates 4/1/13, 4/15/13, 5/14/13, 5/29/13, 6/1113 [sic], 7/9/13, and 7/18/13. (Attachment)"

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2013, March 4, 2013, March 6, 2013, March 13, 2013, May 4, 2013, May 29, 2013, July 1, 2013, July 9, 2013 and July 18, 2013	CPT Codes 97110, 99213, 97002, 99214	$1,169.66	$0.00
March 4, 2013, March 18, 2013, April 1, 2013, April 15, 2013, April 30, 2013, May 4, 2013, May 29, 2013, June 11, 2013, July 9, 2013 and July 18, 2013	CPT Code 99080-73	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the procedures for filing Work Status Reports.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per Rule 129.5.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Did the requestor received payment from the respondent for all services except the Work Status Report?
2. Did the requestor meet the requirements for submission of Work Status Reports?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondents' position summary stated in their position summary that payment was made to the disputed dates of service with the exception of CPT Code 99080-73. The requestor was contacted via e-mail on June 9, 2014 and asked if the disputed dates of service had been paid. The requestor responded to the inquiry stating that all services had been paid except the 73's in question. Therefore, the listed evaluation and management and therapeutic exercise procedure codes are no longer in dispute and will not be reviewed.
2. 28 Texas Administrative Code §129.5(d) states, "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's schedule appointments with the employee." Review of the submitted Work Status Reports finds the requestor has not met any of the requirements of the rule.
3. Since the requestor has not met the requirements of the rule, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 23, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.